Case No. 14-181

In the Supreme Court of the United States

ALFRED J. GOBEILLE, in his official capacity as Chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICI CURIAE* THE NATIONAL ASSOCIATION OF HEALTH DATA ORGANIZATIONS (NAHDO), ET AL. IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICI CURIAE*

The National Association of Health Data Organizations ("NAHDO") is joined by the All-Payer Claims Database ("APCD") Council, the Joint Public Health Informatics Taskforce ("JPHIT"), the Center for Improving Value in Health Care ("CIVHC"), and the Wisconsin Health Information Organization ("WHIO") as *amici* in support of the Petitioner.[1]

Founded in 1986, NAHDO is a national nonprofit membership and educational association, with members drawn from public and private sector health data organizations, including state and federal agencies. NAHDO is dedicated to improving health care data collection and use.

The APCD Council is a learning collaborative that fosters information sharing and best practices among those states which have developed or are seeking to develop all-payer claims databases.

JPHIT is a coalition of nine national public health associations, including the Association of State and Territorial Health Officials ("ASTHO") and the National Association of County & City Health Officials ("NACCHO"), which helps public health agencies build modern information systems across a spectrum of public health programs.

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[1] Pursuant to Supreme Court Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution to its preparation or submission. Pursuant to Supreme Court Rule 37.3, the parties have consented to the filing of amicus briefs and their letters of consent are on file with the Court.

CIVHC is a non-profit, non-partisan organization that helps Colorado drive, deliver, and buy value in health care. CIVHC is also the state-designated administrator for Colorado's all-payer claims database.

WHIO is an independent non-profit organization dedicated to improving the quality, affordability, safety, and efficiency of health care in Wisconsin, and manages a successful voluntary all-payer claims database.

Together, these organizations are deeply concerned about the data gaps and inevitable negative impact to health care reform that results from the absence of employer-sponsored self-funded health plans' data, especially in otherwise comprehensive statewide databases like Vermont's all-payer claims database. They consider this data especially critical since it represents the health care experiences of a large and growing set of working Americans in the prime of their lives, and their families.

SUMMARY OF ARGUMENT

The Second Circuit misapprehended the fundamental nature of all-payer claims database ("APCD") data submissions when it presumed that Vermont's are "burdensome, time-consuming, and risky" and thus pre-empted under the Employee Retirement Income Security Act of 1974 ("ERISA"). *See* Pet. App. 25. The majority, like Liberty Mutual, failed to explain "exactly how" this "obvious burden" manifests. In fact, they could not, because despite the dearth of discussion below, even a cursory understanding of how claims processing and APCD data submissions work dispels the fallacy.

Under this Court's established law, states may not enact statutes that contradict ERISA's core objective "to avoid a multiplicity of regulation[s] in order to permit the nationally uniform administration of employee benefit plans." *N.Y. State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) ("*Travelers*"). However, Vermont's APCD data submissions law does not concern, much less contradict, this core objective. No new or unique record-keeping is required. Moreover, Vermont's claims and eligibility data submissions are typical of those called for by other existing state APCDs and health data aggregation programs, including private, voluntary efforts.

Vermont's statute requires only the extraction, formatting, and submission of claims and eligibility data after it has already been collected, processed, and retained by organizations like Liberty Mutual's third-party administrator, Blue Cross Blue Shield of Massachusetts, in the routine course of business. The statute has no impermissible connection with employer-sponsored self-funded health plans, and thus is not subject to ERISA pre-emption.

Contrary to Liberty Mutual's position that APCD data submissions are overly burdensome and inappropriate, the long-standing consensus position of employers and business groups is that access to independent sources of claims and eligibility data is critical for health care reform. Simply put, Liberty Mutual is out of step with the trend in federal, state, and private sector initiatives, all of which demand increased transparency and measurability in health care.

This case presents the Court with an opportunity to reaffirm its rejection of the overly expansive view of ERISA pre-emption adopted by the Second Circuit, particularly where it thwarts Vermont's eminently reasonable efforts to improve health and health care for its citizens—an area traditionally regulated by the States. The Second Circuit decision should be reversed.

ARGUMENT

I. ERISA's Core Objective Of National Uniformity Is Not Contradicted By Vermont's Mandate To Submit Claims And Eligibility Data.

State law may not contradict ERISA's core objective "to avoid a multiplicity of regulation[s] in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. Vermont's APCD data submissions law does not concern, much less contradict, this core objective.

The Second Circuit misapprehended the fundamental nature of APCD data submissions when it presumed that they are "burdensome, time-consuming, and risky" and "obviously intolerable" as merely one of many "uncoordinated" regimes. Pet. App. 25. As the dissenting judge highlighted, the majority, like Liberty Mutual, failed to explain "exactly how" this "obvious burden" manifests. Pet. App. 39 (Straub, J., dissenting). In fact, they could not, because despite the dearth of discussion below, even a cursory understanding of how claims processing and APCD data submissions work dispels the fallacy.

Employer-sponsored self-funded health plans and their third-party administrators (all of whom we will refer to as "payers" or the "payer") are not required to collect or retain any new records but, instead, need only extract, format, and submit data they already collect and manage in the routine course of business. Moreover, Vermont's mandatory claims and eligibility data submissions are typical of those that payers make to other state APCDs and private, voluntary health data aggregation programs. Thus, Vermont's APCD data submissions law has no impermissible connection with employer-sponsored self-funded health plans.

A. No New Or Unique Record-Keeping Is Required.

The Second Circuit erred by holding that Vermont's APCD data submissions law is pre-empted, in part, because it requires certain "plan record-keeping." Pet. App. 23-25. The claims and eligibility data at issue are already collected and retained by payers in the routine course of business. Here, Blue Cross Blue Shield of Massachusetts fulfills that duty on behalf of Liberty Mutual and regularly supplies Vermont's APCD with claims and eligibility data from its systems for other employer-sponsored self-funded plans. *See* J.A. 205 ¶ 6 (explaining that for 2010 Blue Cross Blue Shield of Massachusetts reported on a total of 7,605 unique members, some 3,667 of whom were members of plans for which it acts as third-party administrator, and "[m]ost, if not all, of those plans are assumed to be ERISA plans").

The form and content requirements for data submissions to Vermont's APCD (and other similar

data aggregation programs) follow a common set of industry-driven technical standards adopted by the U.S. Department of Health and Human Services ("HHS"), under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to standardize electronic transactions between payers and health care providers. *Compare* 45 C.F.R. pts. 160, 162 (adopting industry standards, as detailed below, for standard electronic health care transactions), *with* Vt. Regulation H-2008-01 (Pet. App. 107-141), Apps. C2, D2, & E2 (mapping claims and eligibility data submission requirements to the same standards) ("Vt. Regulation H-2008-01, Apps."), *available at* http://www.dfr.vermont.gov/sites/default/files/REG-H-08-01.pdf. Therefore, contrary to the Second Circuit's holding, no new or unique record-keeping is required.

HIPAA and its implementing regulations ensure health insurance portability and simplify administration by driving standardization among health care providers and payers for key electronic transactions. *See* Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104–191, 110 Stat. 1936; 45 C.F.R. §§ 162.923, 162.925 (mandating adherence to transaction standards for HIPAA covered entities, including health plans and health care providers who interact electronically). These "transactions" span financial and administrative activities, including:

- **Health care claims or equivalent encounter information.**
- **Health care payment and remittance advice.**
- Coordination of benefits.

- Health care claim status.
- Enrollment and disenrollment in a health plan.
- **Eligibility for a health plan.**
- Health plan premium payments.
- Referral certification and authorization.
- First report of injury.
- Health claims attachments.
- Health care electronic funds transfers (EFT) and remittance advice.
- Other transactions that the [HHS] Secretary may prescribe by regulation.

45 C.F.R. § 160.103 (defining "transaction") (emphasis added). Each transaction standard prescribes in detail the data elements and protocol for exchanging the information.

Claims data generally follow a three-step path from health care provider to payer to APCD. First, seeking payment for a patient encounter or other service, a health care provider sends an electronic transaction to the applicable payer (whether public, like Medicare or Medicaid, or private, such as a commercial insurer or an employer-sponsored self-funded plan or its third-party administrator).

This claims transaction must adhere to HIPAA's specifications which, in turn, adopt industry-driven consensus standards, according to the claim type.[2]

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[2] As is true for any health plan-third-party administrator contractual relationship, under its HIPAA-mandated Business Associate Addendum with Liberty Mutual, Blue Cross Blue Shield of Massachusetts "shall be capable of transmitting electronic data for which transaction standards have been promulgated in

For most claims, including medical (both professional and institutional) and dental, HHS has endorsed standards developed by the Accredited Standards Committee X12 ("ASC X12" or "X12"), a broad committee with membership from across the health care and other industries.[3] 45 C.F.R. § 162.1102 (adopting ASC X12N 837 standards). For retail pharmacy drug claims, HHS has adopted standards from the National Council for Prescription Drug Programs ("NCPDP"), which focuses on specific information exchanges within the healthcare community.[4] *Id.* (adopting NCPDP standards). Both X12 and NCPDP are American National Standards Institute ("ANSI") accredited standards developers.

Next, the payer processes the claim. The payer provides information back to the provider and, if appropriate, makes payment, again following HIPAA-specified transaction standards. 45 C.F.R. § 162.1602 (adopting ASC X12N 835 standards for health claim payment/advice and other standards for certain electronic funds transfers). The payer retains claims data in its own record-keeping system. Here, Liberty Mutual's third-party administrator agrees to retain

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compliance with the HIPAA Electronic Transactions Rule, 45 CFR Parts 160 and 162." J.A. 66.

[3] A complete listing of ASC X12 members is available at http://www.x12.org/x12org/mbrship/mbr_list.cfm (last visited Sept. 3, 2015).

[4] A listing of current NCPDP Work Group Co-Chairs, including representatives of payers, such as pharmacy benefits management organizations ("PBMs"), is available at https://www.ncpdp.org/NCPDP/media/pdf/2015_2016_Co-Chairs.pdf. PBMs play a role similar to third-party administrators for processing prescription drug claims and also provide APCD data submissions.

"auditable documentation" for two years (although older claims may be disputed for an additional fee, implying that such data is available). *See* J.A. 89.

Finally, the payer extracts the existing claims data from its system, based on appropriate criteria, and formats it for submission to others to whom it is obliged (or volunteers) to submit data, including, where applicable, one or more APCDs. These claims data extraction and formatting activities are performed on a routine basis. For example, under the *Administrative Services Agreement*, Liberty Mutual's third-party administrator is required to provide it with "a paper copy of a monthly claims listing," or at Liberty Mutual's election, the data will be provided in other forms, including electronic format. J.A. 87-88. Data submissions to Vermont's APCD—like those Liberty Mutual's third-party administrator makes for other employer-sponsored self-funded health plans—occur monthly, quarterly, or annually, according to the total number of individuals for whom it pays claims. Pet. App. 128.

Eligibility data denotes individuals who are entitled to receive care under a health plan, including member demographic information and plan type. The payer's business necessarily dictates that it collect and retain such data regarding its individual members or beneficiaries. As with claims, a health care provider sends an electronic transaction to the payer to inquire as to eligibility and receives a payer response, based on data retained in the payer's system. Again, HIPAA regulations adopt industry-driven consensus standards for the information exchange. 45 C.F.R. § 162.1202 (adopting ASC X12N 270/271 standards for most inquiries and NCPDP

standards for retail pharmacy). For APCD and other data submissions purposes, eligibility data is similarly extracted from the payer's system and formatted accordingly.

By design, Vermont's APCD regulations closely parallel the HIPAA transaction standards for claims and eligibility data. Detailed element by element mappings—found in a series of appendices to the regulation aptly titled "Member Eligibility File Mapping to National Standards," "Medical Claims File Mapping to National Standards," and "Pharmacy Claims File Mapping to National Standards"—assist payers in extracting data and formatting it for submission. *See* Vt. Regulation H-2008-01, Apps. For instance, the "Principal Diagnosis" to be included in medical claims data submissions maps to the same field in the HIPAA-adopted ASC X12N 837 standard. *Id.* at App. D2, 47 (Data Element MC041, Principal Diagnosis, HIPAA reference 837/2300/HI/BK/01-2).

In the scant discussion of burden below, Liberty Mutual implied that some special imposition accompanies Vermont's requirement that APCD claims data submissions "includ[e] such detail as the admission hour. . . expressed in military time HHMM in the case of all inpatient claims." Reply Brief for Pl.-Appellant Liberty Mutual at 17, *Liberty Mut. Ins. Co.* v. *Donegan*, No. 12-4881 (2d Cir. July 17, 2013), ECF No. 88 (internal citations omitted). Yet, that admission time data is no more than the same information for the same field mandated by the ASC X12N 837 standard, adopted in the HIPAA regulations and routinely submitted by providers to payers, as shown in Vermont's mapping. Vt. Regulation H-2008-01, Apps. at App. D2 (Data Element MC019,

Admission Hour, HIPAA Reference 837/2300/DTP/435/03).

B. The Claims And Eligibility Data Submissions Mandated By Vermont Are Typical Of Other State APCDs And Health Data Aggregation Programs.

Vermont's mandatory statewide data aggregation through its APCD offers an effective and efficient approach to ensuring comprehensive representation which, in turn, enables health care cost and utilization studies important to Vermont. Today, the Vermont APCD includes claims data "for 90 percent of commercially insured [fully-insured and employer-sponsored self-funded] Vermonters and 100 percent of Medicaid and Medicare enrollees." Green Mountain Care Board, *Vt. Health Care Uniform Reporting and Evaluation System (VHCURES)*, http://gmcboard.vermont.gov/vhcures (last visited Sept. 3, 2015).

Because the claims and eligibility data submissions required by Vermont closely parallel the HIPAA transaction standards (which in turn adopt X12 and NCPDP consensus standards), the data Vermont collects is typical of other state APCDs and health data aggregation programs. Using a simple but lengthy chart, the United States Health Information Knowledgebase ("USHIK"), maintained by HHS's Agency for Healthcare Research and Quality ("AHRQ"), demonstrates this extensive overlap in APCD data elements and X12 standards across several statewide APCDs, including those of Vermont, Maine, Massachusetts, Minnesota, New Hampshire, and Tennessee. *See* AHRQ, USHIK, APCD to ASC

X12 Relationship Mapping, https://ushik.ahrq.gov/APCDGroupings?system=apcd&enableAsynchronousLoading=true (last visited Sept. 3, 2015).

While the data extraction, formatting, and submissions procedures they prescribe for payers vary somewhat, the similarity in claims and eligibility data collected by state APCDs, including Vermont, is further demonstrated by the references to the HIPAA-adopted X12 and NCPDP standards uniformly made in their data submissions guides.[5] This commonality in the claims and eligibility data aggregated by state APCDs also enables regional studies and resource sharing among states. For instance, such "harmonization" supported a recent multi-state study on variations in health services utilization across Maine, New Hampshire, and Vermont. *See* J.A. 219-20; *see generally* Karl Finison, Onpoint Health Data, *Tri-State Variation in Health Services*

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[5] States that mandate APCD submissions publish a data submissions guide or similar resource instructing payers on appropriate data extraction, formatting, and submission procedures. These guides also provide detailed references enabling payers to link APCD data elements to those in their own systems. *See, e.g.*, Ctr. for Improving Value in Health Care (CIVHC), *Colo. All-Payer Claims Database Data Submission Guide* 12-24, 27-50, 52-58 (Version 6) (March 2014), *available at* http://www.civhc.org/getmedia/c4071074-ecc4-457b-bd40-72fee47ee639/Data-Submission-Guide-V6-March-2014-FINAL_1.pdf.aspx/ (showing references to the X12 and NCPDP standards for claims and eligibility data elements); Access Health CT, *Conn. All Payers Claims Database Data Submission Guide*, Data Content Guides attached to Data Submission Guide 18-69 (Version 1.2 (with clarifications)) (Dec. 5, 2013) (same), *available at* http://www.ct.gov/hix/lib/hix/CT_DSG_-12132014_version_1.2_%28with_clarifications%29.pdf.

Utilization & Expenditures in Northern New England (June 2010), *available at* https://www.apcdcouncil.org/file/112/download?token=9T0EDRtz.

Extracting, formatting, and submitting claims data to APCDs and others is a routine, straightforward process for payers, which already have sophisticated claims processing systems and information technology capabilities. Even so, the APCD community and interested stakeholders regularly collaborate to further streamline the process. This additional standardization speeds up APCD data availability (which by its nature lags behind individuals' receipt of health care services) and facilitates multistate studies. For instance, during the summer of 2011, X12 and the APCD Council began an initiative to develop a "Uniform Medical Claims Payer Reporting Standard" through X12's insurance subcommittee and its working groups. Press Release, X12, *Development of a Uniform Medical Claims Payer Reporting Standard* (Aug. 15, 2011), *available at* http://store.x12.org/store/contact-us/8-news/165-development-of-a-uniform-medical-claims-payer-reporting-standard.

Just one year later, X12 approved publication of several "implementation guides" instructing states and others that aggregate claims data on "eas[ing] the burden for payers required to submit such data, increas[ing] the quality of the data, and reduc[ing] the implementation costs for the health care industry." Press Release, X12, *ASC X12 Announces Technical Reports for Post-Adjudicated Health Care Claims Data Reporting Available* (Aug. 13, 2012), *available at*

http://www.x12.org/x12org/docs/ACFCD5.pdf. More recently, the APCD Council published model legislation to guide states that may be considering APCD authorization. APCD Council et al., *Model All-Payer Claims Database (APCD) Legislation* (May 2015), *available at* http://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation.

These nationwide multi-stakeholder efforts to further standardize APCDs and their data extraction, formatting, and submissions procedures reflect the explicit intent expressed by some state legislatures. For example, Nebraska requires its Health Care Data Base Advisory Committee to "[i]nclude discussions regarding the standardization of the Nebraska Health Care Data Base with other states and regions and federal efforts concerning all-payer claims databases." Neb. Rev. Stat. § 71-9204(1)(g). And in Virginia, where APCD submissions are voluntary, the data "shall be developed in a format that allows comparison of information in the All-Payer Claims Database with other nationwide data programs and that allows employers to compare their employee health plans statewide and between and among regions of the Commonwealth and nationally." Va. Code Ann. § 32.1-276.7:1(E)(1).

Such legislatively-created advisory committees, and other governance structures ranging from boards to consultation requirements, exist in most APCD states and address a wide array of issues. Various business interests, including those of payers and employers, are represented and often specifically identified by state law. For instance, the Vermont Green Mountain Care Board enabling statute re-

quires that the Board "shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the Board," and currently includes payer representation. Vt. Stat. Ann. tit. 18, § 9374(e)(1); State of Vt., Green Mountain Care Board, *GMCB Advisory Committee Members*, http://gmcboard.vermont.gov/advisory_groups/members (last visited Sept. 3, 2015). The Maine Health Data Organization's board must include two representatives of "third-party payors," selected from a group that includes insurers and third-party administrators. Me. Rev. Stat. tit. 22, §§ 8702, 8703.

In another example, Massachusetts's Center for Health Information and Analysis is directed to "consult with . . . affected payers, as applicable, to ensure that the reporting requirements imposed under the [APCD] regulations are not duplicative or excessive" prior to promulgating regulations. Mass. Gen. Laws ch. 12C, § 5. Most recently, Arkansas's law establishes a "Healthcare Transparency Initiative Board" that must include "[t]wo representatives from the health insurance industry" and a self-insured employer representative. S. 956, 90th Gen. Assembly, Regular Sess., at 6 (Ark. 2015) (to be codified at Ark. Code Ann. § 23-61-905) ("*Ark. APCD Statute*"), *available at* http://www.arkleg.state.ar.us/assembly/2015/2015R/Acts/Act1233.pdf.

Finally, payers routinely engage in private, voluntary health data aggregation initiatives that necessarily rely on claims data submissions. California's multi-payer claims database, part of the California Healthcare Performance Information System

("CHPI"), accepts claims data from "the state's three largest health plans": Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare. CHPI, *Multi-Payer Claims Database (MPCD)*, http://www.chpis.org/programs/mpcd.aspx (last visited Sept. 3, 2015). This database includes both insured and self-funded claims, along with Medicare data, representing some 12 million lives. *Id.*

These and other private, voluntary efforts (*see infra* Section III.C) demonstrate the ease with which payers can extract, format, and submit claims and eligibility data for data aggregation purposes. But while the sheer data volume may sound impressive, such efforts inevitably result in only partial views. State-mandated APCDs that aggregate fully-insured and employer-sponsored self-funded claims, as well as Medicaid and Medicare data (like Vermont's and others'), ensure the broadest representation and are uniquely positioned to offer data analyses and reports attuned to local needs. *See* APCD Council, *Interactive State Report Map*, *available at* http://www.apcdcouncil.org/state/map (last visited Sept. 3, 2015) (depicting current and planned data coverage for statewide APCDs). Employer-sponsored self-funded claims data is particularly critical to state APCDs because it represents a growing segment of healthy working adults in the prime of their lives, and their families. *See* Kaiser Family Found. et al., *Employer Health Benefits, 2014 Annual Survey* 176 ("*Kaiser Family Report*"), *available at* http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report (explaining growth in percentage of insured workers covered by self-funded plans from 44% to 61% since 1999).

C. Vermont's APCD Data Submissions Law Has No Impermissible Connection With Employer-Sponsored Self-Funded Health Plans.

Vermont's APCD data submissions law does not "create[] [an] impediment to an employer's adoption of a uniform benefit administration scheme," but instead seeks "to address uniquely local social and economic problems." *See Fort Halifax Packing Co., Inc.* v. *Coyne*, 482 U.S. 1, 14, 19 (1987). The Vermont statute requires only the extraction, formatting, and submission of claims and eligibility data after it has already been collected, processed, and retained by the payer. Thus, it also does not impermissibly "affect[] an ERISA plan's 'system for processing claims and paying benefits.'" *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 150 (2001) (quoting *Fort Halifax Packing Co.*, 482 U.S. at 10).

This Court has concluded that state statutes that have an "indirect economic influence" on ERISA plans do not "relate to" them as long as the statute does not "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." *Travelers*, 514 U.S. at 668. For example, in *Travelers*, this Court held that a state statute requiring hospitals to collect surcharges from patients covered by commercial insurers was not pre-empted by ERISA because it only had an "indirect economic influence" on the cost of insurance policies. *Id.* Similarly, Vermont's statute does not require an ERISA plan to collect new or unique data or to endure any undue financial burdens. As the Second Circuit dissent suggests, the cost of submitting

claims and eligibility data in the required format is minimal and, at most, will have a minor and "indirect economic influence" on ERISA plans, in large part because employer-sponsored self-funded plans (or as in Liberty Mutual's case, their third-party administrators) "already have [such claims data] in their possession." Pet. App. 39-44.

Some state statutes have been held to have a "connection to" ERISA plans if they interfere with "nationally uniform plan administration." For instance, this Court held that ERISA pre-empted a Washington statute governing the payment of benefits—"a central matter of plan administration"—to plan beneficiaries, *Egelhoff*, 532 U.S. at 147-48, and a Pennsylvania anti-subrogation law that "require[d] plans to calculate benefit levels in Pennsylvania based on expected liability conditions that differ[ed] from those in States that ha[d] not enacted similar . . . legislation." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990).

But unlike the state statutes in *FMC Corporation* and *Egelhoff*, the Vermont APCD data submissions law does not require plan administrators to choose between complying with state law or the ERISA plan itself, nor does it interfere with "nationally uniform plan administration" by requiring administrators to offer substantively different ERISA plans in different states. *Compare Fort Halifax Packing Co., Inc.*, 482 U.S. at 14 (concluding that the state's statute "create[d] no impediment to an employer's adoption of a uniform benefit administration scheme" because the law did not "put the employer to the choice of either (1) integrating a state-mandated ongoing benefit plan with an existing plan or (2) establishing a

separate plan to process and pay benefits under the plan required by the State."), *with Egelhoff*, 532 U.S. 141 at 147 (statute pre-empted because it bound "plan administrators to a particular choice of rules for determining beneficiary status. The administrators must pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents.").

Vermont's statute merely calls for claims and eligibility data aggregation, after it has already been collected and retained by payers, to address "uniquely local social and economic problems," such as rising health care costs and the accompanying need for data transparency. This Court's precedent weighs against "disabling it from attempting to address" these issues since the statute "creates no prospect of conflict with a federal statute." *See Fort Halifax Packing Co., Inc.*, 482 U.S. at 19. Moreover, Vermont's APCD data submissions law does not "frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp.*, 498 U.S. at 60.

Finally, below, Liberty Mutual implied (and the Second Circuit apparently agreed) that its ERISA obligations may be thwarted because Vermont's APCD data submissions law requires it to compromise individual privacy. Pet. App. 25, 27-29, 29 n.13. To the contrary, Vermont mandates that payers apply a one-way, non-reversible hash algorithm[6] to re-

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[6] "Hashing" is sometimes referred to as a form of "encryption," but the notable difference is that unlike most encryption schemes that allow for data decryption (i.e., recovery), with an appropriate "key," hashing is a one-way, non-reversible process that replaces the otherwise sensitive data with gibberish.

move data elements that directly identify an individual when formatting (and prior to making) their data submissions, using software that Vermont provides. J.A. 133. As further explained in Vermont's current data submission guide:

> [Vt.'s contractor]'s data collection system ensures that direct member identifiers remain secure — both at rest and in motion — through the use of a federally recommended hashing algorithm. This hashing is not performed by [Vt.'s contractor]; instead, it is performed locally by health plans [or their third-party administrators]. Using [Vt.'s contractor]'s system, all fields specified as "encrypted" in Vermont's Regulation H-2008-01 are hashed upon preparation for submission, remain solely within the health plan's platform, and are neither transmitted nor received by [Vt.'s contractor].

Onpoint Health Data, *Data Submission Guide for the Vt. Health Care Uniform Reporting & Evaluation System (VHCURES)* 13 *(Version 2.0)* (July 2015), available at http://www.onpointhealthdata.org/clients/vhcures/docs/onpoint_vhcures_dsg_v20.pdf. Stated differently, in contrast to the payers' systems, the data maintained by Vermont's APCD does not include the personally identifiable data so attractive to cyber-attackers, and the hashed information cannot be "decrypted" or otherwise recovered. At the same time, requiring payers to use the same hashing software supports important longitudinal studies that

span claims data submitted by different payers, provided that the underlying member data matches prior to its hashing.

II. The Long-Standing Consensus Position Of Employers And Business Groups Is That Access To Claims And Other Utilization Data Is Critical For Health Care Reform.

Contrary to Liberty Mutual's position that APCD data submissions are overly burdensome and inappropriate, employers and business groups have long advocated for and supported greater healthcare data transparency. In the late 1970s and early 1980s, "business health care coalitions," composed mainly of employer-purchasers, grew in response to rapidly escalating health care costs, and data initiatives played an important role. *See generally* Carol Cronin, *Business Coalitions on Health: Their Activities and Impact*, Joint Commission 20 J. Quality Improvement 376, 376-80 (1994).

Such concerns drove the creation of *amicus* the National Association of Health Data Organizations ("NAHDO") in 1986 by the Washington Business Group on Health and the Intergovernmental Health Policy Project at George Washington University in an effort to facilitate coordination among state-level health data agencies and promote public-private cooperation. *See* NAHDO, *About NAHDO*, https://www.nahdo.org/about (last visited Sept. 3, 2015).

These activities have greatly expanded in number and participation—no surprise since today employers provide health benefits for some 149 million non-

elderly Americans, with 61% covered by a plan that is at least partially self-funded. *Kaiser Family Report* at 56, 174.

"Health care performance indicator information is a **public good**, whereby all patients, purchasers, and providers should have access to a common set of performance information." Patrick Miller, *Why State All-Payer Claims Databases Matter to Employers*, 12 Pension & Benefits Daily 114 (June 14, 2012) ("*Why APCDs Matter*") (emphasis added) (quoting Ted von Glahn, senior director, Pacific Business Group on Health).[7]

From the perspective of the business community, APCDs provide an independent source of data, independence being a characteristic important for cultivating employee trust. Nat'l Bus. Coal. on Health,[8] Action Brief, *Price Transparency: Now More than Ever* (May 2012), *available at* https://www.nbch.org/nbch/files/ccLibraryFiles/Filename/000000002934/Final%20price%20transparency.pdf (emphasizing the use of independent data sources to foster employee trust and contrasting Or-

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[7] The Pacific Business Group on Health is one of the nation's most prominent employer-purchaser coalitions, based in no small part on the high profile of its corporate and public agency members. A complete membership list is available at http://www.pbgh.org/about/members (last visited Sept. 3, 2015).

[8] Founded in 1992, the National Business Coalition on Health ("NBCH") includes 52 business health coalitions nationwide that represent over 4,000 employers and some 35 million employees and their families. For more information about NBCH, *see* http://www.nbch.org/About-NBCH (last visited Sept. 3, 2015). A complete membership list is at http://www.nbch.org/NBCH-Coalition-Members (last visited Sept. 3, 2015).

egon's mandatory APCD—created by a neutral party which, in turn, was overseen by an "all-stakeholder" board—to information from health plans, employers, or the government that employees may perceive as biased). Because large, self-insured employers need representative information, "every state[] needs to implement an APCD." *Why APCDs Matter* at 118 (quoting Barbara Belovich, executive director, Health Action Council Ohio).

The value placed on APCDs by the business community is dramatically highlighted in a recent employer-supported 50-state price transparency report card—the only five states with non-failing grades have a statutorily-created APCD. Catalyst for Payment Reform, *Report Card on State Price Transparency Laws* 2 (July 2015), *available at* http://www.catalyzepaymentreform.org/images/documents/2015_Report_PriceTransLaws_06.pdf.[9]

Small business groups also support APCDs as a trusted resource for their employees. Reacting to Washington State's new mandatory-submissions APCD law, the Nat'l Federation of Independent Business ("NFIB") stated, "[small-business owners, employees, and their families] deserve access to meaningful cost and quality information to make informed health-care decisions. This APCD is the foundation for better information and lower costs. . . . Experience in other states has shown that without

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[9] Catalyst for Payment Reform's members include some of the nation's largest employers (*e.g.*, AT&T, FedEx, GE, Walmart), public employee and retiree organizations, and Medicaid agencies. A complete member list is available at http://www.catalyzepaymentreform.org/site-map/cpr-members (last visited Sept. 3, 2015).

a mandate, it is impossible to provide a comprehensive picture of the cost and quality of health care." NFIB, *News Release--Governor Could Finally Give Consumers an Effective All-Payer Claims Database* (Apr. 20, 2015), http://www.nfib.com/article/legislature-passes-health-care-transparency-bill-68901/ (commenting on Wash. E.S.S.B. 5084, enacted May 14, 2015, as Wash. Rev. Code ch. 246, § 2).

Business health care coalitions continue to press for APCD expansion. Despite large-scale voluntary efforts in California (*see* "CHPI," *supra* Section I.B), the Pacific Business Group on Health recently went on the record in support of legislation to create a new "California Health Care Cost and Quality Database" that includes, among other elements, mandatory claims data submissions. *See* S. 26, 2015-2016 Reg. Sess. (Ca. 2015) (introduced May 28, 2015), *available at* https://legiscan.com/CA/bill/SB26/2015; Pac. Bus. Grp. on Health Letter to Bill Sponsor Sen. Ed Hernandez (Apr. 17, 2015), *available at* http://www.pbgh.org/storage/documents/PBGH_SB26_SupportLetterwAmend.pdf (supporting S. 26 with the addition of amendments, "[i]nformation on how well care is provided and how much it costs is important to improving quality and addressing cost containment in California").

Broader health data transparency efforts, including Medicare claims data releases, as called for in the Patient Protection and Affordable Care Act ("Affordable Care Act") have also garnered support from high-profile business groups. *See* Pub. L. No. 111–148, § 10332, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub.

L. No. 111–152, 124 Stat. 1029; *see infra* Section III.A. "The U.S. Chamber of Commerce and our member companies have long advocated in support of the release of medical claims data to facilitate performance reporting that would reflect provider quality and improve transparency while ensuring beneficiary privacy." Letter from Randel K. Johnson & Katie Mahoney for Dep't of Health & Human Servs, Ctrs. for Medicare & Medicaid Servs. ("CMS"), U.S. Chamber of Commerce, *Comment Letter Re: Proposed Rule Regarding the Availability of Medicare Data for Performance Measurement, RIN 0938-AQ17* (Aug. 8, 2011), *available at* http://www.regulations.gov/#!documentDetail;D=CMS-2011-0122-0079 (supporting "broader and richer uses" of Medicare claims data).[10]

Beyond their roles in advocacy and as data consumers, employers and business groups provide hands-on support and leadership for APCDs and other health data aggregation programs. As explained above, many states' APCD authorizing statutes call for advisory committees and other governance structures, populated, in part, by employers and business groups. *See supra* Section I.B; *see, e.g.*,

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[10] It seems incongruous that the U.S. Chamber of Commerce would advocate for greater release of public payer claims data to improve health data transparency, while below, as *amicus*, it argued that similar claims data releases by employer-sponsored self-funded plans and their third-party administrators to state APCDs would have a "deleterious impact" on employers and could even result in employers decreasing the health benefits they provide. Brief of *Amicus Curiae* Chamber of Commerce of the U.S.A. in Support of Reversal at 2, 6, 10-11, *Liberty Mut. Ins. Co.* v. *Donegan*, No. 12-4881 (2d Cir. Apr. 9, 2013), ECF No. 64.

Ark. APCD Statute (specifying Healthcare Transparency Initiative Board members must include representatives of self-insured and small employers); Colo. Rev. Stat. § 25.5-1-204 (APCD Advisory Committee must include representatives of both small and large employers). Board membership rolls for private health data aggregation programs—typically time-consuming volunteer activities for busy businesspeople—provide further evidence of the priority placed on fostering greater data transparency. *See, e.g.*, CHPI, *Board of Directors*, http://www.chpis.org/about/board.aspx (last visited Sept. 3, 2015); Maine Health Management Coalition, [11] *Committees and Workgroups*, http://www.mehmc.org/about-us/committees-workgroups/ (last visited Sept. 3, 2015) (describing its thirteen-member Board of Directors as including seven employers/plan sponsors).

That employers and business groups support the public good provided by APCDs and other health data programs comes as no surprise. They recognize that transparency produces better informed employer-purchasers and employee-consumers, while enabling data-driven cost containment, advocacy, and policymaking. In addition to public reporting and research studies, some creative businesses have sought to benefit even more directly by making their own APCD data release requests. For example, the Maine APCD has apparently accepted at least two data re-

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[11] The Maine Health Management Coalition has received multiple data releases from Maine's APCD. *See* Maine Health Data Organization, *Current Data Requests*, https://mhdo.maine.gov/datarequest.aspx (last visited Sept. 3, 2015).

lease requests in support of self-insured employer reinsurance activities. *See* Maine Health Data Organization, *Current Data Requests* 12-13, https://mhdo.maine.gov/datarequest.aspx (last visited Sept. 3, 2015) (explaining data requests by Integrated Benefit Solutions, LLC and the Human Capital Resource Group).

Individual employers, like Liberty Mutual, inevitably benefit from the increased transparency provided by APCDs and other health data aggregation programs. They should not be allowed to hide behind an overly expansive reading of ERISA pre-emption that this Court has previously rejected and free ride on others' data.

III. Liberty Mutual Is Out Of Step With The Trend In Federal, State, And Private Sector Initiatives Demanding Increased Transparency And Measurability In Health Care.

While the appropriate role of the federal government in reforming the individual and small group health insurance markets may continue to be debated for some time, federal and state policymakers, health care industry leaders, and policy experts have found common ground for more than a decade on the need to improve patient outcomes and reduce the rate of rising health care costs in the United States. In recognition of the need to realign economic incentives across the health care sector, Congress and the Administration have undertaken bipartisan efforts to reform Medicare's payment systems—a key driver of reforms in the nation's other public and private health care payment systems. The success of these

efforts depends in significant part on the availability of data from the broadest possible cross-section of the community to facilitate the measurement of cost, quality, and performance of our health care system.

The most commonly available and standardized data for such purposes are payers' claims and eligibility data. Such data plays a growing role in helping federal, state, and local governments, and private sector stakeholders, meet the challenges of improving "population health"[12] because of its capacity to provide a holistic view of health care consumers' interactions with various components of a community's health care system, including information about the demographics of consumers receiving care, care set-

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[12] As health reform efforts have taken hold in the United States, health policy experts have begun using the term "population health" to refer to "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." David Kindig and Greg Stoddart, *What is Population Health?*, Am. J. Pub. Health, March 2003, at 380, *available at*, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.3.380; *see also* David Kindig, *What Are We Talking About When We Talk About Population Health?*, Health Affairs Blog (April 6, 2015), http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/ (urging that "population health" be used to refer to geographic populations, and that terms such as "population health management" and "population medicine" describe "activities limited to clinical populations and a narrower set of health outcome determinants"); N.Y. State Dep't of Health, *Background and Context for Conducting Literature Review*, http://www.health.ny.gov/statistics/chac/usefulcha/background.htm (last visited Sept. 3, 2015) ("The population health perspective includes a focus on resource allocation and accountability, implying the need for measures of health outcomes and evidence linking interventions to those outcomes").

tings, types and patterns of care, and, given the reimbursement purpose for the data, the cost of care.

Providers have been submitting electronic claims data in a standardized format for over a decade in response to HIPAA and its implementing regulations governing "standard transactions." *See supra*, Section I.A. In contrast, the electronic storage and availability of detailed clinical data was not significantly advanced until the passage of the Health Information Technology for Economic and Clinical Health ("HITECH") Act, enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 ("ARRA"), Pub. L. No. 111–5, 123 Stat. 115.[18]

Clinical data in electronic health records ("EHRs") can provide a more fulsome picture of a particular patient, help identify medical conditions, and facilitate analysis of the health status of a provider group's full patient population. However, while electronic health records hold great promise for broader population health management, particularly when effectively integrated with claims data, the availability of EHRs for such purposes remains limited. Unlike claims and eligibility data, the clinical data contained in electronic health records are not yet sufficiently standardized or shared across organizational, vendor, and geographic boundaries to permit population-wide analytics. Moreover, compared to long-studied claims data, as found in Vermont's and other APCDs, the level of clinical detail

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[18] Despite the broad wording found in Vt. Stat. Ann. tit. 18, § 9410, Vt. Regulation H-2008-01 (Pet. App. 107-141), at issue here, is focused on health plan (*i.e.*, payer) claims and eligibility data.

found in EHRs, including physician notes, may raise further privacy concerns.

A. The Affordable Care Act And The Medicare Access And CHIP Reauthorization Act Of 2015 Are Only The Most Recent Examples Of Bipartisan Federal Support For Greater Health Data Transparency.

In health care reform legislation enacted over the past fifteen years,[14] Congresses led by both parties have sought to leverage the purchasing power of Medicare to drive reform in the health care sector as a whole. Since passage of the Affordable Care Act, efforts have accelerated among public and private purchasers of health care, including employers, to become active purchasers of care at lower cost and higher value. The Secretary of HHS's announcement in January 2015 that Medicare would shift 50 per-

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[14] *See, e.g.*, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106–554, 114 Stat. 2763 (establishing one of the first Medicare pay-for-performance initiatives). Sections 646, 649, & 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066 (creating programs promoting the use of health information technology and pay-for-performance models to improve the care of chronically ill Medicare beneficiaries); Section 5001(b) of the Deficit Reduction Act of 2005, Pub. L. No. 109–171, 120 Stat. 4, and Section 131(d) of the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110–275, 122 Stat. 2494 (authorizing hospital value-based purchasing programs). *See also* Exec. Order No. 13,335, 69 Fed. Reg. 24,059-61 (Apr. 27, 2004) (establishing the HHS Office of the National Coordinator for Health Information Technology under the Bush Administration).

cent of its provider payments into alternative payment arrangements such as accountable care organizations or bundled payments by 2018 was promptly followed by public commitments from representatives of health care payer, provider, and purchaser organizations (including the Pacific Business Group on Health) to have 75 percent of their respective businesses operating under value-based payment arrangements that focus on the "Triple Aim" of better health, better care, and lower costs by January 2020. Press Release, Health Care Transformation Task Force, *Major Health Care Players Unite to Accelerate Transformation of U.S. Health Care System* (Jan. 28, 2015), *available at* http://www.hcttf.org/releases/2015/1/28/major-health-care-players-unite-to-accelerate-transformation-of-us-health-care-system.

Four months later, a Republican-led Congress expanded Medicare data-sharing provisions in the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Pub. L. No. 114–10, 129 Stat. 87, which President Obama signed into law on April 16, 2015. MACRA not only converts Medicare's payment structure for physicians to a pay-for-performance model, it also expands HHS's ability to share standardized extracts of Medicare Part A, B, and D claims data with qualified public and private entities for purposes of "assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care." *Id* at § 105 (a)(2)(B).

Section 10332 of the Affordable Care Act had established the "Qualified Entity" program to allow the Secretary of HHS to provide Medicare claims data

under Parts A, B, and D to Qualified Entities for the evaluation of the performance of providers of services and suppliers—and requires recipients to publish their analyses. 42 U.S.C. § 1395kk(e). MACRA § 105(a) expands the program and, beginning July 1, 2016, allows certain Qualified Entities—including employers—to use Medicare claims data to conduct "private analyses" and provide or sell such data for private use.[15] MACRA leaves unchanged the expectation established in Affordable Care Act § 10332 that Qualified Entities will not rely solely on Medicare data to conduct performance measurements, but will include claims data from other sources. 42 U.S.C. § 1395kk(e)(4)(B)(iii); *see also* 42 C.F.R. §§ 401.703(h), 401.709(b)(2) (establishing a conditional approval process for applicants that do not have access to other claims data at the time of their application to become a "Qualified Entity").

Employers, as defined in ERISA § 3(5), are expressly eligible to receive Medicare claims data analyses for purposes of providing health insurance to their employees and retirees. MACRA §§ 105(a)(1)(B)(i) & (9)(A)(iii). Passage of provisions such as the Qualified Entity data-sharing program reflects Congress's intent to minimize "information silos" in the health care sector and to spur broader data sharing as a means of facilitating delivery and payment system reform at the federal and state levels, and in the private health care sector.

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[15] Insurers may not receive such analyses from Qualified Entities unless they are providing the Qualified Entity with their own claims data. MACRA §§ 105(a)(1)(B)(ii) & (9)(A)(iv).

In further recognition of the importance of the states' role in reform as laboratories of innovation, Congress authorized HHS's Centers for Medicare & Medicaid Services ("CMS") to establish the State Innovation Models initiative under Affordable Care Act § 3021. Social Security Act, §1115A(b)(2)(B)(xi), 42 U.S.C. § 1315a. The State Innovation Models program allows CMS to award grants to states to design and test innovative, state-based multi-payer health care delivery and payment systems that will foster broader innovation and health system transformation to improve population health across communities covered by both public and private payers.

A central premise of the State Innovation Models grant program is that states are in the best position to enlist all stakeholders in the community in contributing to public and private reform efforts. In its announcement of cooperative agreement funding opportunities for "Round 1" State Innovation Models grants in August 2012, CMS's Center for Medicare & Medicaid Innovation (the "Innovation Center") declared:

> States are key partners in developing and testing community-centered health systems and proving that they can deliver significantly improved cost, quality, and population health performance results for Medicare, Medicaid, and CHIP beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with private payers, health plans, and providers, that can help drive and accelerate performance of payment and service delivery models

> across the spectrum of public and private payers. The Innovation Center intends to provide States with funding to design and test models that use the full range of their policy authorities and their ability to convene a broad array of stakeholders, both private and public, to enhance and accelerate the development of innovative health system models that result in better health, better care and reduced costs through improvement.

CMS, Center for Medicare & Medicaid Innovation, *State Innovation Models: Funding for Model Design and Testing Assistance* 2, Cooperative Agreement, Amended Announcement, Funding Opportunity No. CMS-1G1-12-001 (Aug. 23, 2012), *available at* http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf; *see also* Amanda Van Vleet & Julia Paradise, Kaiser Family Found., *The State Innovation Models (SIM) Program: An Overview* (Dec 09, 2014), *available at* http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/.

Vermont's "Blueprint for Health" is an example of the very type of state-led innovation effort the State Innovation Models program is designed to encourage. Vermont was among the first six states to receive a State Innovation Models grant. *See* CMS, *State Innovation Models Initiative: General Information*, http://innovation.cms.gov/initiatives/state-innovations/ (last visited Sept. 3, 2015). Vermont law defines the "Blueprint" as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving con-

trol over health care costs by promoting health maintenance, prevention, and care coordination and management." S. 88, 2009-2010 Sess. (Vt. 2010) (amending Vt. Stat. Ann. Tit. 18, ch. 13).

The Affordable Care Act also reflects Congressional intent that states have adequate means to perform their traditional regulatory role of evaluating health care premium rate increases. Affordable Care Act § 1003 directed the HHS Secretary, "in conjunction with the States," to establish a process for annually reviewing health insurers' rate increases. 42 U.S.C. § 300gg-94. To strengthen states' rate review processes, the Affordable Care Act provided $250 million in grants to enhance states' conduct of "vigorous reviews that assure cost estimates use verifiable medical trend data and realistic administrative cost projections." CMS, *Rate Review Works: Early Achievements of Health Insurance Rate Review Grants*, *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/rate_review_report_092011.pdf; *see also* Sabrina Corlette et al., Georgetown Univ.'s Health Policy Inst., *Cross-Cutting Issues: Monitoring State Implementation of the Affordable Care Act in 10 States: Rate Review* (Sept. 1, 2012).

Forty-three states, including Vermont and the District of Columbia, have received rate review grants. CMS, Ctr. for Consumer Info. & Ins. Oversight, *State Effective Rate Review Programs*, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html (last visited Sept. 3, 2015). Data that reflects a broad cross-section of health care consumers, including the significant segment of individuals, and their families,

covered by employer-sponsored self-funded plans, is an important success factor of these federally-funded rate review programs. *See id.* (explaining that in the course of rate reviews, states should consider, among other factors, cost trends and changes in utilization).

B. The States Have A Long History Of Aggregating Health Data To The Benefit Of Their Citizens.

States have long collected, aggregated, and analyzed a wide variety of health data in order to carry out their population health responsibilities. Examples of such data historically have included disease registry data; vital statistics and demographic data; coroners' reports; clinical laboratory utilization and test results; reports of disease, epidemic, and individual case investigations; data on hospital and post-acute care admissions, lengths-of-stay, and discharges; health care facility survey data; injury and occupational illness data; school absentee data; and information on potential disease vectors and contamination sources in the local environment. Univ. of Ill. at Chi., School of Public Health, *Principles of Epidemiology Course, Lesson 5 Public Health Surveillance*, *available at* http://www.uic.edu/sph/prepare/courses/ph490/resources/epilesson05.pdf.

For over a decade, a growing number of states have recognized that a key element in improving overall population health is understanding the cost, quality, and utilization of health care for their residents by harnessing the valuable information contained in payers' claims and eligibility data. The move toward using claims data to inform quality im-

provement and cost containment efforts began in earnest when Maine established the first statewide APCD in 2003. By the end of 2008, Kansas, Maryland, Massachusetts, and New Hampshire also had established APCDs. By the end of 2010, Minnesota, Tennessee, Utah, and Vermont had enacted legislation to create their own APCDs. Jo Porter et al., Robert Wood Johnson Found., *The Basics of All-Payer Claims Databases: A Primer for States* (January 2014), *available at* https://www.nahdo.org/sites/nahdo.org/files/publications/The%20Basics%20of%20All-Payer%20Claims%20Databases.pdf.

At present, more than thirty states have established, are implementing, or have expressed strong interest in comprehensive, multi-payer databases. *Id.* These databases may include private health insurers' claims, along with data from Medicaid, children's health insurance and state employee health benefit programs, prescription drug plans, dental insurers, and employer-sponsored self-funded plans with Medicare claims data now becoming available through the Qualified Entity program (and CMS's other programs that permit sharing Medicare data with state agencies).[16]

While enormously valuable for studying health care cost, utilization, and other population health issues, claims data stand in contrast to the detailed clinical information, including physician notes, as found in electronic health records. These claims data aggregation programs further protect individual pri-

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[16] *See supra* Section III.A regarding the Qualified Entity program.

vacy by following strict data protection and data release governance protocols, including the use of binding data use agreements. *See, e.g.*, 10 Colo. Code Reg. 2505-5, § 1.200.5 (requiring HIPAA adherence and implementation of a multi-stakeholder data release review committee to advise Colorado's APCD regarding data release requests).

C. Private Sector Health Data Initiatives Demonstrate Feasibility But To Date Provide An Incomplete View.

A wide variety of health care performance data is available from a number of sources, including state and federal agencies, national accrediting bodies, research groups, professional associations, health plans, employers, vendors that aggregate data from multiple plans or employers, and organizations such as the California Public Employees' Retirement System ("CalPERS"), the Pacific Business Group on Health, the Leapfrog Group, Health Action Council Ohio, the New Hampshire Purchasers Group on Health, and the Maine Health Management Coalition. The Leapfrog Group, for example, collects and publishes quality and safety measure data, endorsed by the National Quality Forum, from over 1,500 hospitals that voluntarily participate in its surveys. Leapfrog Group, *LHRP Details for Hosps.*, http://www.leapfroggroup.org/Hospitals/Competitive Benchmarking/4751817. In many parts of the country, local health care coalitions are starting to collect and report physician performance data derived from networks of local health plans, employers, and physician organizations. Gordon Mosser et al., Network for Reg'l Healthcare Improvement, *Regional Coali-*

tions for Healthcare Improvement: Definition, Lessons, and Prospects 18, *available at* http://www.improvingchroniccare.org/downloads/nrhi.pdf.

The Health Care Cost Institute ("HCCI"), a nonprofit organization with nationwide research objectives, is undertaking some of the more ambitious private sector initiatives to gather and leverage health care claims data. HCCI, *About HCCI*, http://www.healthcostinstitute.org/about (last visited Sept. 3, 2015). Through research and access to large payer claims data sets, HCCI seeks to offer answers to critical questions about health care spending and utilization. Demonstrating the value created by collaboration between such private efforts and statewide APCDs, last year HCCI published a report analyzing health care trends of employer-sponsored insured Vermonters younger than 65 and comparing them with national patterns, using data provided by Vermont's APCD. HCCI, *2007-2011 Vermont Health Care Cost and Utilization Report, Executive Summary* 1, *available at http://www.healthcostinstitute.org/files/2007-2011VermontHCCUR_DecemberRevision%2012-11-14.pdf.*

Efforts such as these are important contributors as the country shifts to value-based purchasing, and should be encouraged.[17] However, these national ef-

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[17] HCCI's database of claims and eligibility data does include data attributable to persons covered by employer-sponsored self-funded plans. However, it is unclear whether this model may be executed more broadly given that the sources of this data are primarily large national health insurance carriers that have funded HCCI and that also act as third-party administra-

forts on the part of payers do not include sufficient population in many individual states to permit state-specific analyses. The private organizations also can have limited ability to release financial data, given disclosure prohibitions in the data submission agreements that are part of the voluntary nature of their structure. Moreover, private sector efforts do not obviate the need for mandatory submissions from all payers in the marketplace—including, employers—to meet states' broader population health responsibilities and their key role in cost containment. State-mandated APCDs that aggregate fully-insured and employer-sponsored self-funded claims, as well as Medicaid and Medicare data, are essential to providing the most comprehensive picture possible so that states such as Vermont may achieve the public health missions their legislators have assigned them, *e.g.*, to assess "the capacity and distribution" of health care resources in the state, inform health care policy, evaluate the effect of intervention programs on improving patient outcomes, compare "costs between various treatment settings and approaches," provide information to consumers and purchasers, and improve "the quality and affordability of patient health care and health care coverage." Vt. Stat. Ann. tit. 18, § 9410(a)(1) (Pet. App. 92).

CONCLUSION

For these reasons, the Second Circuit decision should be reversed.

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tors for such self-funded plans. *See* financial statements presented at http://www.healthcostinstitute.org/about.

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